4 University Departments of Rural Health Program

4.1 Introduction
This chapter presents information regarding the national UDRH Program, including:
- the establishment of the national Program;
- a review of the achievement of Program objectives;
- the impact of the Program on national rural health workforce capacity;
- the effectiveness and future role of the Program; and
- enabling and limiting factors contributing to the Program’s achievements to date.

4.2 Background

The UDRH Program was established as a result of the 1996-1997 Federal budget after being identified as a key component of the Government’s Rural Workforce Strategy (Morey 2000). The establishment of the first six UDRHs in 1997 followed a suite of government initiatives implemented over the previous decade to address health workforce needs in rural and remote regions, including the development of several multidisciplinary rural health training units. These units, established between 1989 and 1996, aimed to provide education and training facilities in order to support and attract health professionals to rural and remote communities.

The UDRH Program shared the education and training focus of rural health training units, but differed in its engagement of universities responsible for mainstream and other health professional education, rather than the development of a system outside the mainstream (Morey 2000). In this way, knowledge and skills could be applied to the health problems of rural and remote Australia in a similar way to those of urban Australia (Humphreys 2000).

In its early years, the principal objective of the UDRH Program was identified as the improvement of access by rural and remote communities to appropriate services through the promotion of professional support, education and training for rural and remote health workers and for city-based health care professionals interested in training and practising their clinical skills in a rural or remote setting (Morey 2000). The Department of Health and Ageing itself states that the UDRH Program “encourages students of medicine, nursing and other health professions to pursue a career in rural practice by providing opportunities for students to practise their clinical skills in a rural environment. It also supports health professionals currently practising in rural settings.”

The first two UDRHs were established at the remote centre sites of Broken Hill (University of Sydney) and Mount Isa (originally through the University of Queensland, and later through James Cook University). These sites were selected on the basis of their provision of services to the main groups of rural constituents. A model for these initiatives was provided by Monash University, which in 1992 established the first rural health academic unit in Australia (becoming a UDRH in 2006).

In determining the creation of new UDRHs, medical schools were invited to submit proposals according to defined criteria, including a population health focus, a multidisciplinary approach, cooperation with other institutions and a focus on Indigenous health. In the early stages of the Program eleven program objectives were developed. Following the lapsing program evaluation in 2003, the objectives were refined and a set of key result areas were created in consultation with the UDRHs. The current set of UDRH objectives are as follows (emphasis added).

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Increase and improve **rural experiences for undergraduate students** in the health professions, including training to encourage cultural awareness and sensitivity to Indigenous health issues, for undergraduate students in the health professions;

- Expand **educational opportunities relevant to rural and remote practice**, in particular in relation to existing rural and remote health professionals and Indigenous students;

- Undertake **research into rural and remote health issues**, including publication of papers and reports and applying for research grants and consultancies;

- Provide **training and support** for rural health professionals (including mentors, supervisors and preceptors), consumers and communities, including Indigenous communities;

- Contribute to **innovation in education, research and service development** through collaborations with universities, health services and professional and community organisations, including Indigenous communities;

- Embrace a strong **public or population health focus**; and contribute to the development of innovative **service delivery models** in rural and remote health; and

- Endeavour to progress the rural health agenda within the medical and other health sciences faculties or departments to **maximise the efficient use of resources** provided for a range of rural health programs. These programs include, but are not limited to, the Rural Undergraduate Support and Coordination Program, the Primary Health Care Research Evaluation Development Program and the Rural Clinical Schools Program.

At present, there are eleven UDRHs across Australia. The UDRHs report on a six monthly basis against their objectives and key result areas. Each UDRH is a member of the Australian Rural Health Education Network (ARHEN), which operates as a peak professional body.

There are a range of different UDRH models in terms of organisational structure and operational focus: each UDRH has derived its own operational style and programs to suit local opportunities and needs.

Some UDRHs are run by one university only (e.g. Monash University’s Department of Rural and Indigenous Health), while others are joint ventures between two or more universities (e.g. the Combined Universities Centre of Rural Health in Western Australia, which is a consortium of Curtin University of Technology, Edith Cowan University, the University of Western Australia, Murdoch University and the University of Notre Dame.) Some have multiple sites such as the Northern Rivers UDRH, based in Lismore with established facilities in Murwillumbah and Grafton. Finally, some are co-located and share facilities with a rural clinical school, such as the Spencer Gulf Rural Health School, and the Northern NSW UDRH.

UDRHs have developed a variety of strategies, appropriate for their local contexts, in order to achieve their objectives. This approach was described by several people as characterised by a philosophy of being ‘nationally consistent, locally relevant’. Most UDRHs employed some variation of what appeared to be a common three-part strategy in establishing themselves locally.

1. Developing links with local health services, including Indigenous and other community-based services, through offering support and training for health professionals and facilitating what has been called a ‘cross-pollination’ of ideas and experiences. Most UDRHs have seen themselves becoming a focal point for bringing together people with a common aim of improving health service delivery and population health outcomes.

2. Creating partnerships for student placements, working with local clinicians as supervisors and academics and in return offering academic opportunities for ongoing professional support and access to university facilities such as library resources.

3. Providing a foundation for a rural research culture, through providing training and capacity building support for clinicians in undertaking applied health research, establishing networks and fora for clinicians and academics to meet and discuss research opportunities and ideas, and facilitating applications for research grant funding.
Examples of ways in which these strategies are implemented are reported later in this chapter; however, it can be said generally that the UDRHs as a whole have been successful in establishing an academic infrastructure to support the health professions where such infrastructure had not previously existed. This in itself was counted by some external stakeholders as the most significant contribution of the UDRH within the community, with one local government official speaking of the UDRH as an essential component of the regional centre’s vision to be a ‘learning hub’ which would assist in attracting other academic, scientific and developmental institutions to the area.

The models for UDRH operation are similar across the country, generally with an administrative hub located in a regional centre and often satellite offices in smaller towns, or at the least with links to health practitioners in towns or remote sites away from the regional centre. Student placements can take place anywhere from a regional centre to a small remote settlement, subject to the availability of a health professional as a supervisor and access to information technology (IT) and accommodation for the student. Some UDRHs have taken an interdisciplinary approach to supervising and/or teaching students. For example, nursing, physiotherapy, radiology, occupational therapy and other allied health academics and/or practitioners may teach medical students, while medical academics may have a role in teaching nursing and allied health students. Some UDRHs have an open-door policy to attendance at seminars, skills lab or other sessions and actively encourage a cross-disciplinary learning culture. Advocates of this approach see it as part of the necessary future of health education, given the increasing number of students and shrinking academic workforce.

The broad nature of the Program’s objectives is often cited as one of the strengths of the UDRH Program, allowing each UDRH the flexibility to deliver a local response to the objectives and establish its own organisational culture and ethos. However, the breadth of the Program objectives (and subsequent variation between UDRHs) is also perceived by some as a giving UDRHs a ‘fuzzy’ mandate and a lack of clarity of purpose.

An important component of the local direction of each site has been the influence of the character and management style of the individual leading the organisation. Team culture and inclusive style were cited in several UDRHs as positive components of the organisation to the extent that in some sites a change of leadership or direction has been perceived to negatively impact upon the UDRH’s development and progress. In all cases the shape of the UDRH is informed significantly by the leadership of the key individual/s.

4.3 Achievement of Program objectives

4.3.1 Review of the achievement of Program objectives

All UDRHs are currently meeting their objectives as required in their contractual arrangements with the Commonwealth; regular three-year funding agreements and their corresponding reporting mechanisms have ensured that key performance indicators (KPIs) are monitored.

The challenge to the UDRHs is vast. The national rural health workforce shortage was described by one participant as a ‘wicked’ problem (Camillus, 2008), i.e. one which is multi-dimensional, changes shape or form as potential solutions are implemented, and which is embedded in a larger organisational system and culture. The establishment of the university infrastructure for the UDRHs and the implementation of research, training, and support programs have begun to create a national network of rural health clinicians, academics, students and health service administrators which should in time increase the effectiveness of the rural health workforce. This is a long-term strategy and one which cannot be measured by a single long-term objective such as the increase to the rural health workforce. Other objectives will be required to measure outcomes achieved in the course of reaching the long-term goal. These outcomes include the academic infrastructure (defined as the physical presence of the university as well as the availability of information technology and remote access to academic resources), the creation of an intellectually stimulating network of academics and clinicians, access for rural and remote clinicians to opportunities to teach as well as to access professional development opportunities themselves, and increases in rural health research and publications.
At the inception of the Program the UDRHs had very broad objectives and no identified key performance indicators (KPIs). Following the lapsing program evaluation in 2003, the UDRHs in consultation with the Department developed a series of KPIs on which to evaluate their performance. The KPIs support the key result areas of the Program (the objectives named in section 4.2). The key result areas and the KPIs are monitored through bi-annual reports from the individual UDRHs to the Department. These indicators provide a quantified measure of the activities by which UDRHs are providing rural training for future clinicians as well as research and collaborative activities which are supporting the current health workforce.

Table 5 below summarises the extent to which the collective UDRHs are addressing their key result areas, and shows selected performance indicators. The table provides a snapshot of the level of activity undertaken by the UDRHs and the increase in volume of activity over the years 2004-2007.

Table 5 – UDRH KPI summary data

<table>
<thead>
<tr>
<th>Key Result Area</th>
<th>Selected performance indicators</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Increase and improve rural experiences for health science students</td>
<td>No. students (undergraduate, postgraduate) undertaking placements</td>
<td>3,529(^7)</td>
<td>3,817</td>
<td>3,856</td>
<td>4,398</td>
</tr>
<tr>
<td></td>
<td>Total no. student weeks</td>
<td>14,427</td>
<td>16,675</td>
<td>18,451</td>
<td>17,663</td>
</tr>
<tr>
<td>2. Expand educational opportunities that are relevant for rural and remote practice(^8)</td>
<td>Vocational units or courses: total no. of enrolments</td>
<td>390</td>
<td>768</td>
<td>723</td>
<td>1,198</td>
</tr>
<tr>
<td></td>
<td>Undergraduate units or courses: total no. of enrolments</td>
<td>2,422</td>
<td>2,080</td>
<td>1,623</td>
<td>4,021</td>
</tr>
<tr>
<td></td>
<td>Postgraduate units or courses: total no. of enrolments</td>
<td>830</td>
<td>672</td>
<td>1,105</td>
<td>661</td>
</tr>
<tr>
<td></td>
<td>No. of new research and development projects</td>
<td>106</td>
<td>97</td>
<td>109</td>
<td>122</td>
</tr>
<tr>
<td></td>
<td>Value to UDRH ($)(^9)</td>
<td>2,652,308(^10)</td>
<td>9,685,272</td>
<td>7,871,614</td>
<td>9,237,275</td>
</tr>
<tr>
<td></td>
<td>Total value ($)(^11)</td>
<td>33,655,902</td>
<td>18,963,441</td>
<td>16,678,457</td>
<td>14,624,572</td>
</tr>
<tr>
<td></td>
<td>Total no. publications, reports and articles</td>
<td>202</td>
<td>303</td>
<td>349</td>
<td>453</td>
</tr>
<tr>
<td>3. Undertake research and related activities in rural and remote health issues</td>
<td>Total no. participants in development activities</td>
<td>9,755(^12)</td>
<td>13,045(^13)</td>
<td>13,924(^14)</td>
<td>14,537(^15)</td>
</tr>
</tbody>
</table>

\(^{6}\) Please see section 2.6

\(^{7}\) This figure includes postgraduate placements for July to December 2004 only. January-June figures are unavailable

\(^{8}\) Figures represent unique instances of participation. Note that a single participant may be involved in more than one activity

\(^{9}\) Value to UDRH” for some projects is unavailable

\(^{10}\) “Value to UDRH” data is unavailable for January to June 2004

\(^{11}\) “Total value” for some projects is unavailable

\(^{12}\) This figure includes 1830 participants in a health promotion tour conducted by CUCRH. Grand Rounds participants are excluded from this figure - approximately 1200 participants.
4.3.2 Issues arising in the achievement of Program objectives

The major constraints on UDRHs in their achievement of the Program’s objectives are discussed later in this chapter. In summary, these are:

- funding levels;
- challenges in recruiting academic and clinical staff;
- distance and the challenges of providing either placements for students in more remote towns or providing support to clinicians and communities in more remote locations; and
- workforce pressures on those within the current rural health workforce which constrain the ability to act as supervisors or teachers.

In spite (or because) of these limitations, UDRHs have sought to access additional sources of revenue through grant applications and research consultancies (up to half their annual revenue for some UDRHs), have been innovative in developing joint appointments with local health services, have developed significant IT and other support networks with remote and isolated clinicians, and have provided training and professional development opportunities for clinicians who supervise students.

Some informants believed that the broad nature of the objectives meant that ‘it was left up to us’ to determine the priorities and strategies for establishing the local UDRH. Most UDRH staff considered this to be a benefit, on balance, contributing to the individual character and culture of each UDRH.

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13 This figure includes 800 participants in a sporting activity assisted by SGUDRH UDRH and 2000 participants of promotion activities conducted by SGUDRH at Croc Fest. Grand Rounds participants are excluded from this figure - approximately 4800 participants.

14 This figure includes 2600 participants in National Rural Health Education Forums conducted by Northern NSW UDRH, 386 and 750 participants at career days attended by MICRRH and CUCRH respectively. Grand Rounds participants are excluded from this figure - approximately 1700 participants.

15 This figure includes 2000 participants in a National Rural Health Education Forum conducted by Northern NSW UDRH. Grand Rounds participants are excluded from this figure - approximately 3000 participants.

16 Figures are derived from July-December data only, as collaborations listed in January to June reports may overlap with these. A single collaboration may be listed by more than one UDRH. Therefore figures are approximate only.
4.3.3 Contribution to national rural health workforce priorities

The UDRHs are widely believed to be doing innovative and exciting work, facilitating networking and support for a beleaguered rural health workforce, acting as a catalyst for innovation in service delivery, and fostering a culture of research and evidence-based clinical practice. As one informant observed (and many others agreed over the course of the evaluation) ‘the evidence is thin but the program works’.

According to many informants, the presence of the university within rural towns has enabled local health professionals to remain in clinical practice when they might otherwise have moved to an urban setting. The opportunity to reduce one’s clinical load and take on an academic role has in some instances kept clinicians approaching retirement in ‘circulation’ rather than losing them from the health system altogether. Academic research and teaching opportunities, professional and social networking, and access to continuing education have been some of the contributions named by stakeholders which the UDRHs have provided. These have contributed in some instances to retaining clinicians in rural practice.

‘You can’t say we alone are increasing retention, but you can say that it makes it easier to agree to stay.’ (UDRH nursing academic)

In addition, the university infrastructure in a rural location is itself an attraction and has led to at least some health professionals choosing to practice in the country because of the opportunity to combine clinical practice with academic teaching and research alongside a rural lifestyle. Retention, and the support provided by UDRHs to rural practitioners, are discussed in sections 4.4.1 and 4.4.2.

The UDRH research capacity building strategies, while still evolving, have begun to bear fruit in terms of grants won and opportunities available to individual clinicians seeking to research areas of interest or local need. A number of UDRHs have appointed a research director, and in some cases research staff, and all have undertaken research projects and produced publications. Research and capacity building are discussed in greater detail in section 4.4.3.

The increasing number of student placements which UDRHs organise has anecdotally led to some students choosing to return to country areas. While this is difficult to quantify across the nation, there is evidence both that students increasingly are perceiving rural placements as a positive addition to their education and that an increasing number are expressing an intention to spend time in rural practice at some point in their career. UDRHs have begun to publish their own studies on rural intentions and the effects of placements, from Playford, Larson and Wheatland’s (2006) early article on allied health students in Western Australia to Dalton, Routley and Peek’s (2008) recent survey of Tasmanian health science students. These studies are indicating that placements are contributing to student’s positive perceptions of rural practice and encouraging students’ inclinations to undertake rural practice after graduation. Student placements are discussed in section 4.4.1 below.

The following section outlines in detail the ways in which the UDRHs are implementing their objectives and contributing to national rural health workforce priorities, as well as some of the issues or challenges which attend these activities.
4.4 Effectiveness and future role of the UDRH Program within the context of the current national approach to improving rural and remote health services

This section analyses the UDRHs’ contribution towards two components of the national rural health workforce aims: increased workforce capacity; and increased training and support for the rural health workforce.

4.4.1 Increased workforce capacity

There is evidence that the UDRH Program is contributing to increased workforce capacity in three ways, through: the provision of student placements (the potential future rural workforce), continuing education opportunities for health professionals (the current rural workforce), and assistance and development of research and innovative health service delivery models (the capacity of the health care system and professionals within the system).

Student placements

The scope of the UDRHs to act as facilitators for rural student placements for a variety of health disciplines means that they are in an excellent position to provide multidisciplinary training, and most of the UDRHs see this as a core activity. Students have reported their enthusiasm for this aspect of placement.

‘There is a much greater emphasis on a multidisciplinary approach which I much prefer because you learn a broader range of skills…one of the highlights [of the placement] is to be working more closely with other disciplines.’ (physiotherapy student)

‘UDRHs’ impact is broadening support for other disciplines…It’s really good to break down the barriers and bring people together.’ (National Rural Health Student Network member)

Placements for undergraduate students from a variety of health disciplines constitute a significant portion of any UDRH’s activity, in 2007 ranging from 177 placements at one UDRH to 619 at another. Collectively, the UDRHs have supported and coordinated placements for over 15,000 students over the past 4 years. As demonstrated in Figure 3 below, the number of student placements and the number of student weeks has increased over the last four years.

Although all UDRHs act as facilitators in the arrangement of rural exposure placements for health students, the extent of this involvement differs. In some instances UDRH staff are involved in direct teaching of the curriculum while, in others, UDRH staff simply arrange accommodation and placement with a clinical preceptor, and in a few instances placements are arranged through the disciplinary faculties without consultation with the UDRH. Student placements are facilitated for a range of medical, nursing and allied health disciplines, from collaborating universities and more broadly. The large majority of UDRHs support placements for five or more disciplines, and some do so for up to fifteen. These placements have been noted elsewhere as a positive factor in encouraging students to consider rural careers (Playford, Larson and Wheatland 2006, Schoo, McNamara and Stagnitti, 2008, Dalton, Routley and Peek 2008). Students appear to benefit from the exposure to country life and from exposure to a wider range of clinical work than they might experience in an urban setting.

One student described her time with the UDRH as ‘going beyond a placement’: the benefits included being able to get involved with community events, go out with the ambulance on calls, provide physiotherapy for the local footy team, and work with other disciplines. As for this student, many students and academics perceived benefits of placements to be far more comprehensive than simply the educational outcomes and included exposure to a rural lifestyle, the ability to work in teams, and exposure to a wider variety of clinical practice than a student might normally experience in an urban setting.

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17 Figures sourced from the Department of Health and Ageing
An added benefit of a university presence, noted by both UDRH staff and external stakeholders, is the opportunity for local people to consider further study. These opportunities pertain to high school students as well as qualified health professionals, thus providing locally-based career pathways. As an example, James Cook University’s School of Nursing collaborates with the Mount Isa Centre for Rural and Remote Health to provide a local nursing course so that people can remain in Mount Isa while studying rather than having to travel to Townsville. The Broken Hill UDRH has developed a health career ‘pipeline’ model which promotes health careers to Indigenous and other school students through schools programs targeting specific educational stages, from activities for pre-primary school children, with a health promotion focus, to Years 7-12 ‘Nursing Academies’ which provides high school students with hands-on exposure to nursing practice. In Moe, the Monash University Department of Rural and Indigenous Health (MUDRIH) has succeeded in engaging a number of local health professionals in Master’s studies, strengthening the research and evaluation skills of key members of the existing workforce, and providing access to senior academics by professionals who would otherwise be absent from the workplace to travel to Melbourne for the stimulation of further study.

Distance is a reality for anyone living and working in rural Australia, and this is noted by UDRHs (as well as by RCSs) as a limiting factor in providing placements and supervision for students. UDRHs may place students at some distance from the UDRH centre and many UDRHs have worked hard to ensure that they are able to provide academic and personal support to students and clinicians in remote locations. An outcome of this is the ability to assist other university academic departments in developing their own rurally-focussed programs. One pharmacy department within a collaborating university used their UDRH as an example in providing support to their own students on placement. A key lesson to the department was the importance of the quality of the supervisory relationship and the relational aspects of mentoring and supporting students on short-term placements.

‘It’s made us think – how do we deliver our placement program, and now we are making sure the students have mentoring, personal visits, workbooks. The placements are for seven weeks so that personal interaction is important. We have adopted lessons learned from [the UDRH] as we work to improve the way we do things.’ (pharmacy academic)

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18 Placements are of one week or longer in rural or remote sites organised or facilitated by a UDRH
19 See section 3.2.1 for a discussion of the rural pipeline model.
Multidisciplinary training is often a feature of student placements or exposure tours which bring together students from diverse disciplines. This is considered to be an opportunity for students to build awareness of team models and to learn to work with other disciplines. An example of this is the Country Week Program, organised by the Combined Universities Centre for Rural Health in Western Australia, in which students spend a week in a rural community and work in multidisciplinary teams exploring topics relating to the health of the community. The aim is to guide students to understand health issues within a broader social and cultural context. The program has been well received by students, health practitioners and community members, and it is now being developed into a program for lecturers.

However, the opportunities for multidisciplinary learning arguably have not been fully realised. There are several reasons for this, including the fact that medical students in the majority of RCSs study the set medical curriculum which may or may not align with the placement requirements of other disciplines. The exceptions to this tend to occur at the RCS sites which offer a Parallel Rural Community Curriculum (PRCC) which is more flexible. Nursing and allied health students on placements are also generally in rural areas for a comparatively short period of time compared to most medical students at rural clinical schools who tend to spend a year in one location. Finally, while in some places there are RCSs and UDRHs that may share clinical training labs or teaching space, the planning processes for disciplines is not usually shared and unless close collaborative mechanisms exist it appears to be difficult to break down the disciplinary silos (this point is discussed further in section 4.5.2).

Collaborative care is recognised as delivering better patient outcomes in a range of settings, and is actively encouraged by a number of incentive items under Medicare. The UDRHs are well placed to facilitate increased opportunities for interprofessional education (IPE).

"The more that health service delivery goes down an integrated primary health care direction, the more valuable it will be to have a UDRH in your neighbourhood. It's through the UDRH that you can get research done, education and evaluation of what you do."

(UDRH academic)

The University of Tasmania has plans for its RCS and UDRH to collaborate on IPE learning opportunities in the near future. In some locations such as the University of Melbourne in Shepparton, where the RCS and UDRH are co-located, a clinical simulation laboratory offers opportunities for students to learn together with registrars from the hospital on the same site, with simulations including participation from hospital nurses and registrars. A number of UDRHs have developed and delivered cross-disciplinary teaching units. For example Broken Hill UDRH has developed a geriatric medicine rotation for medical students which is delivered by medical, nursing, occupational therapy, physiotherapy and other allied health professionals (despite having no geriatrician in Broken Hill). There is scope for this type of activity to increase.

There is limited evidence to date indicating that students who have undertaken a rural placement through the UDRH Program have actually returned to take up full-time practice within a rural environment. However, a recent study (conducted by staff of Northern NSW UDRH) found that 46% of the allied health workforce of a region of NSW had undertaken an undergraduate rural placement (Smith et al 2008); the fact that nearly half of the current workforce has done so suggests both a fairly young workforce and that the experience of a rural placement may influence an individual's decision to return to the country to work after graduation. During the consultation a number of anecdotal reports were given of people who had chosen to return after having undertaken a rural placement, including two who returned to the same UDRH as academics following graduation within their respective health disciplines. One of these students was of rural origin and had always intended to have a rural career. The other, however, accepted the academic opportunity as a good career move without intending to relocate and spends weekends in the city where friends and family are situated.

Given the number of students who have had contact with the UDRHs, the proportion of students to date who have chosen a rural career is quite small. However, perceptions of careers are changing amongst younger Australians, and it is more likely now that a student will choose to work in a variety of locations over the course of their career. It may be that the changing nature of mobility within Australian society

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20 For instance, through the Medicare item numbers for coordinated care and care plans.
means that some of these students will rotate in and out of rural settings, thus contributing to the rural workforce over time. A great many of the students consulted in this evaluation expressed a willingness or desire to spend some time practising in a rural or remote setting, though they did not necessarily envisage settling permanently in a rural location. It may also be true, as many UDRH staff argued, that it will take time for the absolute numbers of rural health clinicians to increase, given other factors which may influence an individual’s career choice. Some have suggested that longer placements (akin to those offered by rural clinical schools) may have greater impact in encouraging people to make a future lifestyle decision to relocate to the country from the city. This would allow nursing and allied health students to have an experience similar to that of medical students in the RCS Program, who live within a community for an extended period of time and learn what it is like to be part of a rural community. There would, of course, be funding implications of this sort of placement program, and it would require close collaboration with those within Schools of Nursing and other disciplines with regard to an expanded rural teaching component of the curriculum.

Retention

There is anecdotal evidence that the presence of a UDRH in a rural or regional area has contributed to the retention of local health practitioners. While one UDRH staff member said that they ‘haven’t seen any evidence that this is working (as a workforce initiative)’ others have argued strongly that there is good evidence that the UDRH is contributing to the workforce in several ways. Several UDRHs were able to speak about increases in applicant numbers to health professional positions, as an indication of the growing interest in working rurally where there are opportunities to combine clinical and academic work. Some UDRHs insist that all academic appointments include a clinical load, so any increase to the UDRH staff is also an increase in the local health workforce. Others have claimed that the UDRH helps to retain existing health workers through providing new intellectual and clinical teaching opportunities, as well as providing access to professional development.

‘The number of physiotherapy students here has gone up 400%, we have a new graduate at the local community health centre, and another full-time graduate working with a practitioner in town. A lot [of local practitioners] didn’t want to have students but are seeing the benefits.’ (UDRH staff member)

‘Remote area nurses have one of the hardest jobs in Australia – they’re under enormous pressure and require clinical skills far beyond most nurses… By offering serious training and formal qualifications we not only increase the quality of care provided in remote locations, but also the job satisfaction and resilience of these nurses to continue on with what they’re doing, rather than burn out, quit and go back to the cities.’ (UDRH staff member)

The contribution of the UDRH to the local community as an employer, and as an attraction for health practitioners, who may have an opportunity to undertake a joint academic and clinical appointment, has been argued. The physical presence of the university within the rural town may itself raise expectations of improved health care, as well as a heightened awareness of the efforts being made to address the workforce shortage.

‘I knew this town [before the university arrived] and even just the physical presence of the university and knowing that they’re working on the workforce issues – this is valued by the community. It has brought educated rural people an opportunity to live and work in a rural setting; people want to contribute to the community but not at their own expense of lifestyle.’ (UDRH staff member)

The attraction of the UDRH as a rural employer is considered to be due to a combination of educational and support structures, opportunities to participate in research and teaching, the availability of educational facilities, the growing presence of an academic and health professional community and the networks that have been established. Conjoint positions are said to offer an attractive mix of research and teaching in addition to clinical work.

‘Putting academics in rural areas highlights workforce issues; it provides additional support to help [local clinicians] survive.’ (medical academic)
In Broken Hill, for example, joint medical officer positions are offered by the UDRH and the Royal Flying Doctor Service (RFDS). This has brought three new doctors to the region, positions that would not otherwise be filled due to funding constraints and the difficulty of recruiting people for dedicated teaching or clinical appointments. Together, the RFDS and UDRH can offer a more attractive salary than could be offered by the UDRH alone. In Shepparton, the School of Rural Health has negotiated joint appointments for some clinical staff between the UDRH and the hospital across the street.

4.4.2 Increased training and support for the rural health workforce

Examples of continuing professional education for health practitioners include discipline specific and interdisciplinary workshops and courses, mentoring and support to graduates, research skills training, and training for clinical supervision. Table 6 below presents data on the number of enrolments in courses or units delivered by, or in association with, the UDRH.\(^{21}\)

**Table 6 – UDRH course enrolments**

<table>
<thead>
<tr>
<th>Education type</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vocational</td>
<td>390</td>
<td>768</td>
<td>723</td>
<td>1,198</td>
</tr>
<tr>
<td>Undergraduate</td>
<td>2,422</td>
<td>2,080</td>
<td>1,623</td>
<td>4,021</td>
</tr>
<tr>
<td>Postgraduate and research</td>
<td>830</td>
<td>672</td>
<td>1,105</td>
<td>661</td>
</tr>
</tbody>
</table>

Examples of graduate education include the following:

- In Victoria and South Australia, Greater Health (the Greater Green Triangle UDRH) developed and implemented a needs assessment-based continuing education program for allied health professionals; this subsequently evolved into a state-wide program in Victoria. The program utilises video conference broadcasts to enhance access to practitioners.

- **Broken Hill UDRH** has developed the ‘Enhanced Isolated Practice Program’ which aims to increase knowledge and skills relevant to rural and remote settings and plans to introduce, in conjunction with the Area Health Service, a health service management training course to increase the capacity of health practitioners to deal with management issues.

- The **Centre for Remote Health** (based in Alice Springs) has had a strong focus on postgraduate study, including development of Master’s courses in Remote Health Practice (with streams for medical, nursing and allied health professionals) and Remote Health Management. These degrees also offer exit points at Graduate Certificate and Graduate Diploma levels.

- The **Centre for Remote Health** has also developed a series of short courses in response to the training needs of remote health professionals. One example is the Pharmacotherapeutics for Remote Area Nurses course, which is now delivered in a number of locations across the Northern Territory, Western Australia and South Australia and has become part of the mandatory training requirements for remote area practitioners in all three States/Territories.

- There are plans at Greater Health to develop ‘bridging’ training for allied health workers in their early career years, in response to a perception that a number of allied health workers are exiting the profession early in their career as they do not feel adequately supported. This course would

\(^{21}\) The UDRH must be responsible for 50% or more of the teaching. Note that figures represent unique enrolments. A single participant may enrol in more than one unit/course
provide practical training in building a practice as well as strategies for coping with challenges such as isolation and lack of local professional development opportunities.

The following case study illustrates the effect which rurally-located educational opportunities can have on a person’s career path.

**Case Study – Professional development for a remote area nurse**

Isabelle began her early career as a remote area nurse. In time she took up an opportunity to further her studies in health by enrolling in a Master’s degree, which she conducted via distance learning (before the introduction of email and internet to the region). As her career progressed, Isabelle developed a strong interest in telehealth. This led her to further postgraduate studies in communication and multimedia, and subsequently to a position within the State health service coordinating a project involving the use of telehealth in service delivery. This was pioneering work at the time, with implications for remote area health more broadly, so Isabelle aimed to develop the study into a PhD. Isabelle was passionate about this area of work, but she struggled to overcome the challenges presented by the PhD, including a lack of prior research in the area and an absent academic support network. Isabelle was the only person in the region to have attempted a PhD and she felt isolated and frustrated to the extent that the PhD reached a standstill.

On completion of the telehealth project, Isabelle was offered a position with the *Combined Universities Centre for Rural Health*. At CUCRH, Isabelle found herself in a completely different environment. She was surrounded by researchers at all levels, including those attempting or holding PhDs. CUCRH fostered a culture of critical enquiry and debate, and provided very strong and structured support to researchers in the form of supervision, mentoring and research skills training. In this environment Isabelle was able to successfully complete her PhD and as she now points out, ‘you couldn’t help but learn how to do it’.

Following completion of her PhD, Isabelle’s career continued to develop. After spending eighteen months at a senior academic appointment at a regionally-based Australian university, Isabelle is now back at CUCRH in a senior managerial role. Isabelle finds that CUCRH offers her a unique opportunity to pursue her research and academic interests while conducting clinical work in her area of passion: remote area health service development. ‘It’s great to have the opportunity to help Australia increase health access to remote areas… we are starting to see some real improvements’. Now seen as an expert in her field, Isabelle was a delegate to the National Rural Health Summit and is continuing to contribute to rural health policy reform. ‘The UDRH enabled me to do so much more than I would have thought possible… I’m [now] doing what I love. I just want to keep going as long as I can.’

Another benefit provided by the UDRH is the ability to access funding for research through the PHCREDP Program, and opportunities to undertake graduate studies without having to leave the regional area. In the *Northern NSW UDRH*, for example, a number of local health practitioners have participated in the UDRH’s Researcher Development Program and have gone on to enrol in Master’s and PhD courses.

‘The best part about working here (UDRH) is the flexibility to work with my lifestyle… I want to do a Masters or a PhD and am mulling over topics at the moment. I know (UDRH directors) will support me. I can do that and still be with the community and look after my kids’. (UDRH staff member)

**Preceptor training**

Because of their considerable involvement in facilitating student placements, most UDRHs have an active preceptor training program that aims to provide training and support for health professionals who take on the responsibility of acting in a clinical supervisory role. The *Centre for Rural Health* runs short courses for supervisors and also incorporates supervisory training into the postgraduate program, so that health professionals leave the *Centre for Rural Health* prepared to act as preceptors. MUDRIH has negotiated a unified preceptor training program across their region, and CUCRH conducts training
which is available via electronic technology to multiple sites, and which is publicised through the State-
wide Country Health Service as well as through personal contacts and AMSs. Over the past four years,
an average of 56 people undertook basic preceptor training and 48 people undertook advanced
preceptor training each year through CUCRH.

A rolling program of workshops for preceptors in pharmacy and allied health is conducted throughout
the year at Northern Rivers UDRH, and at Northern NSW UDRH a program called ‘Teaching on the
Run’ is provided for clinicians to enhance teaching skills. At Spencer Gulf Rural Health School
(SGRHS) a series of workshops and seminars have been developed for GPs as well as allied health
clinical educators.

There is a diversity of perception regarding the impact of students on clinical practice, with most
informants considering that practice-based training is beneficial for the clinicians as well as the
students.

‘The large number of nursing students that rotate though the aged care facilities] helps to
increase the morale of the nursing staff – it makes them feel like they are the experts who
are doing the teaching.’ (nursing academic)

The question of whether students actually increased the workforce was contested, with some
informants considering that students provide helpful assistance and become an extra pair of hands, and
others considering that students require more time to supervise, taking attention away from busy
caseloads. On balance, more people considered that it was a positive experience, and a few cases
were reported where students were essential, such as one instance where students assisted remote
community members under the radio or telephone guidance of a Royal Flying Doctor Service (RFDS)
doctor.

‘If they hadn’t been there, the patient would have died. In remote communities, just having
the students there automatically increases the workforce.’ (RFDS Officer)

Sometimes, however, students are seen to add to the pressures of the current workforce; many
potential preceptors choose not to take on students for supervision. At times, placements are not
always managed in a way that is sensitive to the demands of the workforce.

‘It takes a lot of energy to take students; we’re used as a resource, but don’t always know
when they’re coming [into the hospital].’ (clinician)

‘I’m the only paediatrician in the region and running my own business, so I simply don’t
have the time to take on any students.’ (clinician)

Interprofessional education
A characteristic of the UDRHs, which is considered to be a strength, is their multidisciplinary nature.
Among rural health professionals, UDRHs promote interprofessional education (IPE), facilitating or
creating opportunities for various disciplines to work and train together.

For example, the University of Tasmania UDRH staff have spent time working with local rural
communities regarding population health issues, conceptualising service models to address these
issues. This has allowed them to gain in-depth knowledge about emerging local health issues and to
address them through innovations in service delivery models including IPE, flexible service delivery
models, interdisciplinary care and service integration. The UDRH staff understand their role as
contributing to health workforce planning and believe that they could have a more significant role in the
future, at a State and national level, particularly with regard to IPE. The State health department has
formed a strategic alliance with the UDRH to further the department’s approach to rural health
workforce planning.

Another area of support provided by the UDRHs is their establishment of health professional and
academic networks. These connections in themselves are perceived to break down feelings of isolation
and lack of support. One remote nurse claimed that because of the local UDRH’s efforts to increase
communication and engagement with health professionals across rural and remote regions,
‘People don’t feel so alone anymore.’ (remote nurse)

In some UDRHs, IPE has been developed to the extent that there is teaching across disciplines, so that depending on the subject nurses or physiotherapists may teach medical students, nursing students may be taught by doctors, and students from different disciplines may come together for joint classes or training.

4.4.3 Increased rural health research capability and output

Research capacity building is perceived to be a core achievement of the UDRHs. The number of publications produced by UDRH staff and associated clinicians has increased substantially over the lifetime of the Program, totalling 453 publications, articles and reports in 2007. Among individual UDRHs this figure ranged from 11 to 68. Figure 4 below illustrates the growth in collective UDRH publications over the last four years.

Figure 4 – Number of publications, articles and reports produced by UDRHs by year

Most UDRHs are engaged with research capacity building under the auspices of the Primary Health Care Research Evaluation and Development (PHCRED) Program, a strategy of the Department of Health and Ageing which includes a number of initiatives aimed at increasing evidence-based practice within primary health care. Under this strategy, the Research Capacity Building Initiative provides funding to UDRHs and other bodies to support health practitioners in developing research skills and undertaking research activities in the primary care setting. In practice, this enables UDRHs to offer fellowships to local health practitioners to undertake research projects, and to provide a network of support for professionals who are seeking to improve their research skills.

Many UDRHs are offering research skills training (e.g. research skills workshops, evidence-based practice workshops, research forums, and reading groups) to local health professionals. For example, in Tamworth the Northern NSW UDRH used PHCRED funding to develop a Researcher Development Program, which has included research skills workshops, evidence-based practice workshops, research forums and other educational events, as well as PhD and research project supervision and mentoring. This has reportedly provided stimulation and enthusiasm to local practitioners who may remain in rural areas longer as a result of the additional intellectual and social engagement. The Northern Rivers UDRH has established two research networks: the Aboriginal Health Research Network involving AMS and local area health service staff working in Aboriginal-specific services; and the Mainstream Primary
Health Care Research Network involving primary health care clinicians working in mainstream services in rural, northern NSW in either the public or private sector. In Mount Isa, the Centre for Rural and Remote Health employs a dedicated Research Director whose role is to develop the research capacity of local practitioners through a variety of workshops, projects and fellowships.

A criticism of the opportunities offered through the PHCRED Program was offered by one stakeholder who believed that the standards expected are too high and unattainable for many health service workers. This stakeholder was concerned that opportunities were lost for more practical and actionable research. In contrast, a staff member of another UDRH described their activities in the following terms:

’[We are] building awareness of research but there’s not yet the capacity, and people leave so you’re always starting over - we are moving along slowly. People who really want to do it will do it anyway, but PHCRED funding helps to encourage people. It’s good for developing a cultural shift to a positive view of research; you do need a basic level of research literacy [to build a research culture]’.

It does appear that for some clinicians the ability to access research funding and support has influenced their decision to remain in rural practice.

’It was a really positive experience for me, and these sorts of opportunities definitely have an impact on retention – they provide you with alternative activities and new areas of learning which is intellectually stimulating…These things mean that a rural area doesn’t seem to be a backwater’. (PHCRED bursary recipient)

Some stakeholders advised that the value of PHCRED and the partnership with the UDRH could not be underestimated in terms of building capacity of rural health professionals at a Master’s and PhD level.

’I would never have thought that there would be this much support available to me to complete my Masters … it has been integral to the whole process, the UDRH staff have provided so much advice and assistance. I am now seriously considering going on to do my PhD… something I would not have thought of doing before.’ (PHCRED bursary recipient)

It appears that one of the benefits which UDRHs have brought to rural regions is the possibility of engaging in research, so that people who might not have considered even local research projects into an area of interest, much less undertaking a higher degree, are now considering opportunities to do so. The network described in the case study below is one such catalyst for partnerships in health service and clinical research, a model which may have scope for expansion and transferability to other regions.
Case study – Rural Health Academic Network

The Rural Health Academic Network (RHAN) was established by the University of Melbourne UDRH, part of the School of Rural Health at Shepparton, and launched in 2006. The RHAN encourages and actively supports the development of rural health research with an emphasis on creating and nurturing academic-community and academic-health service partnerships. The RHAN also encourages the engagement of multidisciplinary investigative teams.

The RHAN has a number of overall aims and objectives, including achieving and supporting excellence in rural and remote health research. In order to do this, capacity building is a key component of the RHAN strategy. The vision of the RHAN is to create a supportive infrastructure to facilitate the investigation of issues relevant to the health of rural and remote communities from population and health service perspectives. The RHAN has a number of principles and values that it strives to achieve. These include:

- **Relevance** - Making sure rural research matters;
- **Collaboration** - Challenging traditional boundaries;
- **Diversity** - Recognising the reality of rural and remote living; and
- **Innovation** - Respecting resourceful approaches

The network is an innovative concept and has formed collaborative partnerships, for research, education and capacity building purposes, between the School of Rural Health (both Shepparton and Ballarat Campuses) and initially eight key rural health services across the state of Victoria (Echuca Regional Health, Alexandra District Hospital, Seymour Memorial Hospital, Goulburn Valley Health, the Goulburn Valley Department of General Practice, North East Health Wangaratta, Upper Hume Community Health Service and the Upper Murray Health and Community Services). Each health service has a research officer embedded in the organisation (jointly funded by the health service and the University of Melbourne) to facilitate and enable coordinated research and research capacity-building across the region. Funding from PHCRED also assists individuals who undertake research projects.

The RHAN was recently downsized to five sites due to lack of funding. However, the network was considered to be valuable enough for one local health service to choose to fund the research officer position themselves, and another community remained engaged with the network even though the research position was not renewed there.

The network is considered to have had a positive impact on local clinicians, and after two years UDRH staff perceive an increase in research projects, with growing opportunities for collaboration between providers. The profile of RHAN has grown as well, and its inclusive approach has also included local community groups who have been able to participate in research projects of special interest to them, such as women’s health. More than one UDRH staff member stated that RHAN has contributed to workforce retention because of the presence of academics in rural places with their increased ability to support local people. ‘It’s encouraging the workforce to work in smarter ways, to develop a variety of skills – both clinical and research’.

Through one UDRH, a local GP was able to use a PHCRED bursary to trial a collaborative care model for co-morbid chronic diseases. The project was particularly important for his work as a GP and the community he served because of the elevated incidence rates of chronic disease in the region. He said:

‘We would never have been able to start this as a project without the UDRH. We needed their knowledge base and clerical base to get it going.’
Another GP stated that:

‘[The UDRH] provides the academic framework that GPs can work with. We had no direct links with universities previously. This [research] underpins the quality and sustainability of our work… [The UDRH] is supporting clinicians in a real way to get practices involved in research.’

Across a number of UDRHs the impact of the PHCRED program has been very positive in building and strengthening the research culture – solidifying an academic environment which encourages intellectual pursuits. There are a number of examples of local health practitioners who undertook postgraduate degrees while remaining in their rural employment, whereas previously they would have had to move to the metropolitan centre to undertake further study.

However, the uptake of the opportunities for research fellowships appears to vary widely across UDRHs, with one UDRH staff member remarking that

‘the funding is available but not usually taken up by local clinicians, and not often by medics.’ (UDRH staff member)

Collaborations with UDRHs have enabled a number of health service providers to investigate their own research questions and to evaluate their own services; projects that would not have otherwise been possible. As an example, one UDRH recently partnered with the local area health service to conduct a local study to identify the reasons for a decline in screening for high blood lead levels in children. An action plan was subsequently developed for the health service and this is currently being implemented. According to stakeholders within the health service, the study would not have been able to go ahead without the UDRH due to limitations in resources, skills and capacity.

‘Being involved in research just makes my every day work more interesting and stimulating, it adds another dimension… The [UDRH] researchers are so helpful and skilled, which has improved my research skills. I have often thought that without this I would have moved on ages ago.’ (local clinician)

The University of Tasmania UDRH has played a key role in providing assistance to local services and agencies in evaluating population health projects, in 2007 developing a project to map community health and wellbeing. There has been very positive feedback from local services and agencies to this project, which provided crucial evaluation expertise to ensure a rigorous output. The UDRH also focussed on capacity building within the local services and agencies to enable them to build evaluation into their ongoing project work.

Some UDRHs are demonstrating limited research output. In some instances, this is a consequence of being in an earlier stage of development, with plans in place to develop this aspect of the UDRH activity in time. Elsewhere, research has been a secondary priority, with the primary focus being on student placements.

In addition to individual UDRH research activity, the International Electronic Journal of Rural and Remote Health Research, Education, Practice and Policy22, managed through ARHEN and FRAME, has encouraged a wider international audience of practitioners and researchers in the areas of rural and remote health issues. This provides a forum to increase networks and communication across a range of issues influencing rural health service delivery. Roughly one-quarter of the articles published in the journal have authors identified with a UDRH (27% in issue 3, 2008).

Research topics
The range of research topics in which UDRH staff are engaged is extensive; however, there is a significant focus on three areas:

- rural workforce issues, including recruitment and retention;

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22 www.rrh.org.au
- population health issues; and
- innovative health service delivery.

As an example of the latter, Greater Health is conducting a project to develop, test and implement a model for assessment and treatment of co-morbid depression, heart disease and diabetes within general practices. This involves training the extended team, both within and external to the general practice surgery, to manage an integrated shared care model which can be sustained under the Medicare Chronic Disease Management items.

Other examples of population health research topics from a range of UDRHs include participation and volunteerism, planning for future health needs of rural elderly citizens, falls prevention, the impact of sea change, program evaluation and service planning, screening for life-threatening diseases in remote areas, sexual health, alcohol and other drugs, early childhood and youth services research, physical exercise, racism and bullying and sustainable farming families.

**Case study – ‘Your Health in Your Hands’**

The Spencer Gulf Rural Health School (SGRHS) research program has worked closely with the local community in Whyalla to identify health issues of importance to the community. The community were very keen to improve their overall health and wellbeing, especially the self-management of chronic diseases. As a result of this consultation Whyalla was chosen as one of the sites for the South Australian Sharing Health Care project which focussed on rural and remote communities. This research program involved the testing and refining of a range of new approaches to chronic illness self-management.

In response to this the SGRHS community engagement project, ‘Your Health in Your Hands’, was established. The project was designed to trial the application of self-management principles for a group of people with complex chronic conditions over a three-year period. Chronic health management issues were researched and investigated and the SGRHS provided self-management training, to increase peoples’ knowledge of their conditions and empower them to manage their care more effectively.

The project also provided community leader training and ‘train the trainer’ programs. The project was so successful that the community arranged for an independent resource centre to be established in the town. The ‘In Our Hands’ 23 resource centre is now fully self-sustaining and is run by a thriving volunteer group providing the Whyalla community with a place where they can go to obtain health-related information, including verbal information, pamphlets, access to internet resources and a variety of courses. Volunteers are trained to provide the public with support 5 days per week. A team of highly trained peer leaders facilitate all the courses. The facilitators also run courses outside the resource centre for other service providers and organisations.

The success of this project allowed the SGRHS to roll out this model of care to other chronic illness initiatives in Aboriginal Health Services, community health organisations and GP surgeries. The research team has developed a range of promotional materials and published articles, posters and conference pieces based on outcomes from this project.

These examples notwithstanding, there has been some criticism within some communities of the lack of focus on implementation of research at the service delivery level. In some instances it was felt that better consultative mechanisms were required to ensure research results are practical and can be used by those on the ground. In one example, GP workforce research conducted by the UDRH had not adequately met the needs of GPs so was repeated by the Division of General Practice. On the other hand, some UDRHs have been actively engaged in the piloting of service delivery models, preferring to engage locally in practical research which directly addresses workforce pressures.

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An innovative service delivery trial, announced in August 2008 by the Queensland Health Minister (Robertson, 2008), will seek to pilot the use of physician assistants in the Australian health system. This trial has been championed by the Mount Isa Centre for Rural and Remote Health, and seeks to determine whether the physician assistant role can alleviate the workforce pressures on doctors. While the announcement of the trial has raised some controversy (Hall, 2008), the trial is an example of the ways in which some UDRHs are working in collaboration with a range of service providers to pilot innovative research in service delivery models.

A number of UDRHs are conducting research into workforce recruitment and retention issues; some of these were described in the literature review found in chapter 3 of this report (see for example Hegney et al 2002; Durey, McNamara and Larson 2003; Lee and Mackenzie 2003; Schoo et al 2005; Guion et al 2006; Gum 2007; Dalton, Routley and Peek 2008). The studies aim to identify the impact of UDRH programs, such as student placements and continuing professional education, on recruitment and retention of the local workforce and also seek to identify the key factors influencing career choices and reasons to stay in rural and remote regions. This work promises to provide useful data, but as yet it is too early to see the full impacts of these activities, specifically whether student placements provide lasting increases to the rural workforce.

Some UDRHs have been more explicit than others in setting overarching ‘themes’ that connect the various research and teaching activities (e.g. the Centre for Remote Health in Alice Springs focussing on remote primary care, the Monash University Department for Rural and Indigenous Health in Victoria having an explicit focus on Indigenous health). Aside from the numerous benefits reported from such theming, one drawback is that not all research topics of interest to all stakeholders will rise to the top of the list of research to be undertaken. For example, one hospital manager reports that they have ‘good data and research topics currently going begging’ because the UDRH has already focussed its attention on other topics. This is something which might be addressed through effective consultative mechanisms with the local health service network in order to shape a common research agenda including locally relevant primary health issues.

4.4.4 Relationships with other initiatives and with key stakeholders

The broad mandate of the UDRH Program has required each UDRH to develop relationships with a range of local and national stakeholders, such as community groups, local area health services, national peak bodies, and the UDRH network itself.

One aspect of the UDRH Program which has been perceived across all UDRHs to be beneficial is the establishment of ARHEN, the Australian Rural Health Education Network, which functions as the peak body for the UDRHs. Initially, the establishment of ARHEN was supported by seed funding from the Department of Health and Ageing. However, dedicated funding ceased after two years and the UDRHs chose to fund the ongoing network themselves, with each UDRH contributing equally to support an office and administrative staff from their own institutional core funding and with the consent of the Department to use core funding for this purpose.

ARHEN offers a mechanism for collaboration between the eleven UDRHs. In addition to organising a series of sub-networks (such as a network for Indigenous UDRH staff, a research network, and so on) ARHEN seeks grant and funding opportunities which may be of benefit to the UDRHs collectively, and also facilitates cross-university information and learning opportunities, such as a yearly research symposium. ARHEN supports the electronic Journal of Rural and Remote Health and was the catalyst for the recently published Textbook of Rural Health, produced by ARHEN (2008) with funding from the Department. The extent to which ARHEN is valued by UDRHs can be seen by their decision to continue funding the ARHEN infrastructure each year. ARHEN was considered by some UDRH Heads to provide a ‘fantastic ability to become more than the sum of the parts’, through facilitating collaboration and providing a forum for the exchange of ideas. It was acknowledged, however, that the lack of dedicated funding for ARHEN had encouraged the UDRHs to become more innovative as a network and to seek out grant and other funding to achieve their aim of contributing to health service development and innovation.
Networks and relationships are a key characteristic of UDRHs and an essential component of their ability to meet their objectives of examining population and public health issues, contributing to innovation in education, research and service delivery, and providing training and support for health professionals, consumers and communities, including Indigenous communities. Table 7 below presents the number of collaborations in which the UDRHs were actively engaged in the first half of 2007.

Table 7 – Number of collaborations in which UDRHs were actively involved July to December 2007

<table>
<thead>
<tr>
<th></th>
<th>University based</th>
<th>State/Territory Health Services</th>
<th>Aboriginal community controlled organisations</th>
<th>Professional bodies</th>
<th>Other organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007 July – December reporting period</td>
<td>153</td>
<td>75</td>
<td>39</td>
<td>80</td>
<td>117</td>
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</tbody>
</table>

The degree to which each UDRH has developed networks and collaborations is significantly influenced by the nature of its leadership and key staff members. Over time, these relationships have resulted in a number of innovative partnerships. UDRHs, by their very presence, have the capacity to act as facilitators for partnerships and innovation by bringing together diverse groups and providing structures and resources for collaboration to take place.

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24 Figures are derived from July to December reports only, as collaborations listed in January to June reports may overlap with these. A single collaboration may also be listed by more than one UDRH. Therefore figures are approximate only.
Case Study – the Australian Rural Health Research Collaboration (ARHRC)

The Australian Rural Health Research Collaboration (ARHRC) demonstrates a strategic partnership arrangement that expands the quantity and quality of research on rural and remote health issues and through its governance ensures that the focus remains on rural community public health issues.

The ARHRC is collaboration between four centres, three within the School of Public Health, University of Sydney Faculty of Medicine, and one from the University of Newcastle. The academic centres are Broken Hill UDRH, Northern Rivers UDRH at Lismore, the Centre for Rural and Remote Health at Orange (University of Newcastle) and the Australian Centre for Agricultural Health and Safety at Moree. In partnership with each centre’s local area health service, the Collaboration was established in 2003 with the assistance of a $1.5 million grant under NSW Health’s Capacity Building Infrastructure Grants Program. It was subsequently successful in applying for a second round of triennial funding which will take it through to 2009.

The Collaboration was established to address important health inequalities between rural and urban communities. Specifically, its goal is to undertake research that leads to sustainable improvement in rural health and informs national and international audiences.

The Collaboration's program covers the following key areas:

- research capacity-building;
- agricultural health and safety;
- environmental health;
- health services research;
- mental health research;
- remote and Indigenous health research; and
- translation of research into improved practice.

The Collaboration is governed by an Advisory Council with representation from the universities involved, the four local area health services and industry and community representatives. The Advisory Council facilitates vital partnerships between academia, industry, health services and local communities and assists in defining the research agenda.

The benefits of such a collaboration include increased capacity to undertake larger-scale research projects that an individual centre may not be able to undertake on its own; forged linkages between research centres with a rural and remote health focus (e.g. NRUDRH and the Centre for Rural and Remote Health at Orange are collaborating on a mental health services research project amongst agricultural communities, BHUDRH and NRUDRH are collaborating on an NHMRC-funded project investigating the prevention of cardiovascular disease in rural communities); increased capacity to source research funding; and increased capacity to attract high quality researchers due to an expanded profile. The involvement of area health services, other health representatives and communities through the Advisory Council also helps to maintain the focus of research on emerging health issues in rural and remote communities.
Engagement with the university sector

The UDRHs are a workforce initiative funded through the Department of Health and Ageing, but are fully integrated within the Commonwealth funded university sector. As departments within Australian universities, the UDRHs operate within the structures and cultures of their own institutions, while progressing a mandate which is parallel to the educational goals of the university sector. As one UDRH Head described it,

‘the universities are more about competencies, but our role is to help people to understand working in a rural community.’

The UDRH role, therefore, includes contributing to the educational goals of the university while at the same time seeking to promote rural health careers to students, and to support and engage existing rural health practitioners. The UDRH leadership understands that the UDRHs form a ‘hybrid’ group – not a standard education provider but health service oriented as well.

Senior university representatives involved in this consultation understood this hybrid position of the UDRHs. Depending on the university, UDRHs were generally structurally located within the Faculty of Medicine, or of a Division of Health Sciences. In some places they are structured within a broader department including primary health care, general practice, or other disciplines or, if closely aligned with an RCS, often appearing as part of a distinct rural school or division. This placement of the UDRH within the university structure did seem to influence the extent to which the UDRH was prominent within the policy and decision making echelons of the faculty. To some extent the placement of the UDRH, and its visibility within the university or faculty, was perceived by UDRH staff to be an indication of the importance placed on rural health training by the institution. The significance of this is most clearly seen in the way in which universities promoted or did not promote rural health training opportunities to their students.

‘Rural health is not always taken seriously by the “city”, there is a perception in rural areas that the city people do not understand rural health.’ (UDRH student co-ordinator)

Several university stakeholders reflected upon the tension between the UDRH Program as a workforce initiative and the UDRH as a component of the education sector. One Head of Faculty remarked that the UDRH was where

‘the rubber hits the road – the impact of DoHA funding on the university is important because universities had lost their way; this [Program] requires something of universities in terms of applied intelligence.’

In other words, the UDRH Program requires universities to consider the outcome of tertiary education in terms of practical application, and in particular the extent to which universities are preparing health practitioners to serve rural communities. This same interviewee noted that

‘this is one of the few truly Australian and innovative things we’ve done – it needs to continue.’

At the same time, there is room for improvement. It was noted by several university stakeholders that the lack of targets for nursing and allied health students, such as those which require a proportion of medical students to undertake rural training, has meant that nursing and allied health rural placements are not seen as a priority or as an integral part of health education which the university is required to address.

‘There should KPIs around the numbers of allied health students that the UDRH have to meet; this would then be a driver for the university to promote the rotation and promotion of rural placement of allied health students.’ (university pro-vice chancellor)
Others recognised the need to compete within the university environment and to create a ‘space’ in which UDRH with its unique workforce mandate can establish its credibility to advocate for strengthening the rural health workforce and service delivery.

‘One issue is that because [the university] has a strong academic and research department in their own right, there is a risk they could lose sight of the greater DoHA national agenda, and at the moment this is not always on people’s minds day to day.’ (UDRH Head)

One Head of Faculty responded to the question of the UDRH’s impact on rural health workforce capacity by saying,

‘Absolutely! Because without the UDRH program we wouldn’t have facilities in [rural town], and rotate a lot of students through a high quality teaching experience [in different types of sites]...Its strength is [being] multidisciplinary. The capacity of the UDRH is unique. It builds awareness of team models, and students are more aware, they know how to relate to other disciplines.’

Speaking about the university’s perception of the impact of the UDRH (and by extension the university) on the rural community, another Head of Faculty simply said,

‘The UDRH’s involvement with the community is awesome.’

The extent to which UDRHs interact actively with local communities, service providers and State/Territory-funded health services in seeking to influence and develop rural health systems sets them apart from more traditional education delivery. Several university stakeholders acknowledged the difficulty of proving causality from the UDRH Program to increased rural workforce recruitment, but all believed that funding should continue ‘for another 10 years’ in order to give time for a number of student cohorts to graduate and make decisions about where they will practice.

Community engagement

On a community level, there is evidence that UDRH collaborations are building local capacity and resilience. As an example, the Combined Universities Centre of Rural Health is taking a lead role in the development of a culturally secure therapy support model for remote areas. The Aboriginal Therapy Assistants Program will employ locally based Aboriginal Therapy Assistants to provide assistance to allied health professionals, thus extending the services and support available in those regions. A range of appropriate training resources will also be developed.

In an initiative aimed to attract more clinicians to the region, the Northern NSW UDRH in Tamworth collaborated with the local council to develop a new primary health care model called Peel Health Care. The model is a managed interdisciplinary general practice based in the town centre and was established using a grant from the Regional Partnerships Program (now run by the Australian Government Department of Infrastructure, Transport, Regional Development and Local Government) as well as community donations. The rationale for the model is to enable clinicians to work on a sessional basis, without the costs, administration or risks associated with establishing a sole practice. The practice also provides educational opportunities for UDRH and RCS students, as well as registrars and residents.

As an example of building links with the local community as well as the health professional community, several UDRHs have focussed attention on the mental health needs of farmers and their families as a result of long-term drought. In one UDRH, academics arranged a series of community information sessions on mental health for farmers in a rural region of the State. This was felt to be helpful to the local community but also demonstrated the credibility of the academic presence in the region, and that the university was there to strengthen the community.

‘The local presence [provides] so many more benefits than the fly-in-fly-out model.’ (UDRH academic)

Another UDRH is collaborating with a number of partners to trial a model of youth health promotion. One of the key aims of the Social Norms Analysis project is to empower schools and rural communities by...
to implement their own social norms interventions; the UDRH will develop a resource kit to facilitate this process.

All of the UDRHs have established a management committee or advisory board which includes community representation. These links appear to have been most advantageous in the early years of the UDRHs, when they were establishing themselves within the community and were seeking to build relationships with local leaders. For those UDRHs which have been operating for quite some time, this formal relationship with community members is supplemented by other relationships which have developed over time through UDRH involvement in local projects and initiatives, and by UDRH staff developing personal and social relationships through residence in the town.

Engagement with Indigenous health practice

Indigenous health is considered to be a cornerstone of the UDRHs; it is named within their objectives and is spoken of by most staff as a priority. However, the degree to which Indigenous health is pursued as a priority issue is contested by some stakeholders. While most UDRH staff indicated that Indigenous health and engagement with communities was important, others, including some Indigenous staff and community members, felt that the depth of community consultation and relationship with the local UDRH could be improved.

Nevertheless, the focus and achievements of a number of UDRHs in relation to Indigenous health issues must be recognised.

Over several years Monash University Department of Rural and Indigenous Health has invested in Indigenous education programs, with an Indigenous Health Unit involved in teaching, research, and projects that investigate and deliver information about Indigenous health to students in all disciplines within the faculty. The inclusion of Indigenous health and its social determinants are now compulsory components of the undergraduate curricula in medicine, nursing and some health sciences. The Indigenous focus of MUDRIH is reported to reflect the commitment within Monash to ensure students across disciplines have access to Indigenous health practice.

The Northern NSW UDRH is currently developing a large-scale longitudinal study investigating the health issues of Indigenous mothers and their babies, aiming to address the high rates of low birth weights and poor health outcomes for Indigenous babies in the region.

In Whyalla the quality of care to Indigenous people has reportedly improved as a result of the Spencer Gulf Rural Health School. One of the student coordinators, who is also a health worker, is permanently located at the Pika Wiya Health Service (an Aboriginal Community Controlled Health Organisation). Students placed at the Pika Wiya are required to be closely engaged with health issues that affect the local Aboriginal community. For example, in one project students and AHWs conducted home visits and spoke with pregnant women, identifying the issues and barriers which affected their attendance at the health service. As a result of this research, special clinics have been initiated to conduct comprehensive health assessments aimed at finding practical solutions to health issues. All allied health students involved in a rotation at the Pika Wiya health centre do self-directed projects and produce resources for the centre that aim to benefit the local Aboriginal community.

Many UDRHs work with local AMSs to facilitate short-term student placements for nursing and allied health students. During these placements the students might assist with clinical practice under supervision, or undertake projects to support practitioners. An example of this includes the media student placements undertaken by the Combined Universities Centre for Rural Health, in which CUCRH has provided opportunities for media students from Edith Cowan University to work with rural radio stations, newspapers and the local AMS to develop positive and culturally appropriate health promotion messages. This project is facilitated through the structures which already exist for allied health and nursing placements.

While it is commonly stated that these student placements are benefiting local Indigenous communities, some stakeholders have mentioned an ongoing concern that decisions regarding the placements, their frequency, and the impact on the service providers and clients, need to be consistently negotiated with the local service and not simply assumed. The level of genuine reciprocity in the relationship between UDRHs and Indigenous services was questioned by some informants who felt that there could be
improvements in the way in which UDRHs seek to build partnerships with local Indigenous health services for the purposes of providing student training.

‘Community members notice these things. There used to be a sign up saying that we were partners but the sign was taken down.’ (Indigenous community member)

One of the most consistent areas of activity is not in the area of direct Indigenous health service provision, but in the delivery of cultural training to non-Indigenous students and health practitioners. This appears to be an area where there is a continuing need for training, but where deliverables can be measured, and results are evident in increased understanding of Indigenous cultural issues and their effect on health service access.

‘We provide ‘cultural proficiency’ training, try to get people to see what the ‘other’ looks like…it will help service delivery [if people understand what Aboriginal people perceive].’ (Indigenous UDRH staff member)

Table 8 presents the number of students receiving cultural awareness training as part of their placement.

Table 8 – Number of students receiving cultural awareness training each year as part of their UDRH placement

<table>
<thead>
<tr>
<th>Cultural awareness training</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of students</td>
<td>958</td>
<td>947</td>
<td>1018</td>
<td>1681</td>
</tr>
</tbody>
</table>

The level of training and educational opportunities for local Indigenous communities differs considerably. Several UDRHs have provided training for Aboriginal Health Workers to certificate level, and provide ongoing training for AHWs once they are qualified.

‘It’s not possible for lots of people [to go to the city to train] so we went to [remote town] and ran the course there. Twenty people signed up and 19 finished…it’s an important process, people without an education getting training; it’s given them a choice.’ (UDRH Indigenous academic)

Table 9 below demonstrates the number of Indigenous students that have participated in units and courses delivered by (or in association with) a UDRH. There does not appear to be a consistent trend to these results, with no clear increases in numbers over time.

Table 9 – Number of Indigenous student enrolments in units/courses delivered by a UDRH

<table>
<thead>
<tr>
<th>Number of Indigenous student enrolments</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>138</td>
<td>148</td>
<td>52</td>
<td>103</td>
</tr>
</tbody>
</table>

Some UDRHs have embraced the role of providing a model for increased participation by Indigenous people in mainstream health services, by promoting and employing Indigenous people themselves. The presence of Indigenous staff has also been noted as a key success factor to developing positive working relationships with local Indigenous communities. Eleven percent of UDRH staff are Indigenous (ARHEN, 2007). Some UDRHs have made a deliberate effort to employ a number of Indigenous staff

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25 Figure includes undergraduate and postgraduate students
26 The UDRH must be responsible for 50% or more of the teaching. Figure includes undergraduate, postgraduate and vocational units/courses
appropriate to the local demographics, and in a few UDRHs Indigenous staff members are employed at senior staff levels. However, across Australia in general there is a lack of senior representation by Indigenous academics, and this has been noted by Indigenous staff themselves.

‘What’s really lacking is Aboriginal people in senior positions, it’s a thorn in the UDRHs’ side. The universities are not generally welcoming, and there is a lack of leadership roles [e.g. Aboriginal people at A/Professor and Professor levels]. There are no Aboriginal directors of UDRHs.’ (UDRH Indigenous academic)

Another said,

‘In the beginning I felt that people weren’t listening – there was no one except me – but it’s grown…the UDRHs needed to be doing more, but now it’s getting better. It was mostly the medical model early on, but it’s changed.’ (UDRH Indigenous academic)

There was a general sense expressed by UDRH staff involved in Indigenous health that the UDRHs were sincere in their desire to address the community and population health issues and to contribute to improving Indigenous health. It was acknowledged by some UDRH staff, however, that the way in which this was pursued in the beginning was not always sensitive to the culture of Indigenous people. On the other hand, a staff member of an AMS believed that their local UDRH had been very understanding and culturally appropriate in engaging with the community, providing locally relevant health promotion material as well as student placements, which the informant considered to be valuable.

‘It’s two way – we both receive…it’s a partnership neither side takes for granted.’ (AMS staff member)

The ability to provide greater opportunities for Indigenous staff as well as professional development pathways is an issue identified by ARHEN (2007) in their paper regarding the future role of the UDRHs. One Indigenous staff member suggested that training needed to start even earlier than current initiatives, sending positive messages to children before they even reach school that there are opportunities available to them so that they can see education as a positive undertaking.

‘Capacity building starts with ante-natal clinics, then when kids go to school you need to nourish them, give them evidence that education makes a difference.’ (Indigenous UDRH staff member)
**Case study – Capacity building for Indigenous health providers**

Sylvia was working as an Indigenous Health lecturer at a remotely located TAFE when she first encountered the Combined Universities Centre for Rural Health. At the time Sylvia was restricted to teaching early level courses due to her limited formal qualifications. She found it frustrating, but further studies felt out of her reach due to family constraints. ‘I had to hold back from over-teaching even though the students were keen.’

Sylvia was encouraged to do some part-time work with CUCRH and in doing so discovered a new Graduate Certificate in Indigenous Health Promotion course that the UDRH had developed and was delivering. Completion of this course would enable Sylvia to teach higher level courses herself. The course was well suited to Sylvia’s circumstances as it offered support and allowed a flexible self paced learning style which could fit around her work and family commitments. Sylvia took up the opportunity and soon found that she loved it. ‘It was great - knowing that I did have a brain and something to offer.’ Within a year of starting she had completed the course.

This success encouraged Sylvia to enrol in a Bachelor of Nursing that was also coordinated locally by CUCRH, who provided her with tutorial, travel and accommodation support, as well as assistance in liaising with the university. She had access to all the facilities at CUCRH, which included her own office space. Arrangements were also made for her to receive a fellowship to work on a CUCRH project which would be included as a course unit. Sylvia graduated with three others from the region. A special local graduation ceremony was arranged which was attended by family and friends, CUCRH staff and staff who travelled from the base university.

After graduating, Sylvia entered the hospital graduate program, which then led to a full time hospital position. Following this she was offered a position on an Indigenous workforce project at CUCRH. The position sounded challenging, but Sylvia felt able to take it on with the knowledge of the support and encouragement she would receive.

Two years later she is still with CUCRH, enjoying working on projects that she sees have a direct positive impact on Indigenous communities in the region. She continues to develop her own skills and says ‘I really surprised myself with some of the things I’ve learnt.’ Most importantly, the UDRH offers the flexibility she needs to maintain her family commitments and she feels blessed to work somewhere that is trusting and supportive. Sylvia now has her sights set on postgraduate studies.

**Relationships with other initiatives**

The Rural Undergraduate Support and Coordination Program (RUSC) provides funding for medical students to undertake short-term placements in rural locations (see Program parameters in Appendix E). The RUSC Program pre-dates the UDRH and RCS Programs, and was part of a strategy to increase rural exposure opportunities for medical students in order to encourage rural medical careers. RUSC funds are given to the university medical school, and the way in which the funds are disseminated differs according to the university structures and priorities. Some universities retain the RUSC funding within departments of general practice, while others apply the RUSC funding through the RCS Program. In some instances, RUSC funds are devolved to the UDRH, for the management of a particular rural exposure program for medical students. In at least one instance, this is considered to deflect attention and core funding (through provision of staff time and administrative costs) away from providing opportunities to nursing and allied health students in favour of coordinating a large number of medical student placements. Some UDRHs combine RUSC funding with their own programs to provide a multidisciplinary experience of rural life, bringing together students from a range of disciplines to spend a week together in a small town, exploring areas of health delivery and learning from each other about each discipline’s approach to health needs.

There is some potential for administrative efficiencies to be gained through integrating the coordination of student placements. In one co-located RCS/UDRH site, one support coordinator organises placement of all students through the RCS, UDRH and RUSC programs, thus streamlining program and
student placement management. In another, prior to the establishment of the RCS the UDRH had a major focus on medical student placements. Under the co-located model, the medical students are now channelled through the RCS, freeing up UDRH resources to refocus on nursing and allied health students, and other areas of the UDRH mandate such as support, professional development and research.

A UDRH’s relationship to the local RCS differs from university to university as well. In some instances, the Programs are integrated to the point of inseparability, as at Shepparton where the University of Melbourne’s School of Rural Health incorporates both the RCS and the UDRH. Here, the UDRH pre-dated the RCS and the integration of the two has led to the influx of a considerable infrastructure as a result of RCS funding, infrastructure such as library and clinical simulation facilities which have benefited students from the UDRH as well. While funding streams remain separate for transparency and accountability, in practice staff work across both Programs and the School promotes a single identity for health education and support for the local workforce. In other locations, the UDRH and the RCS retain collegial relationships without overt collaboration.

Most UDRHs have developed collaborative relationships to varying degrees with other workforce support initiatives such as the General Practice Networks (formerly the Divisions of General Practice) and the rural workforce agencies. Depending on the local circumstances, UDRHs may also work closely with the Royal Flying Doctor Services and other non-government or private service providers, and almost invariably the UDRHs have developed relationships with an extensive network of local service providers, from paramedics to hospital nurses.

ARHEN has been successful in acquiring funding for a number of projects which bring together researchers from individual UDRHs and provide a national perspective on rural health issues; the Allied Health Service Program Review is one example of this (Larson, Stirling, Burch, ARHEN 2007). Members of ARHEN generally felt that there is great potential for more collaborative work of this nature and that much could be achieved by working together across UDRHs.

4.5 Enabling and limiting factors

4.5.1 Enabling factors

A number of key factors were identified which had led to the achievements of the UDRHs to date. While each UDRH had its unique characteristics of local geography, personalities, and confluence of circumstances, several foundational characteristics appear to be required for the UDRH to reach its objectives. These are outlined below.

Leadership

Several of the UDRHs are still lead by their founding Directors, providing a sense of stability and continuity both within the individual site and amongst the Program nationally. Because of the broad nature of the UDRHs the leadership within the national Program is accordingly diverse, including both clinicians and non-clinicians. This diversity has contributed to the different ways in which UDRHs have operationalised their remit in their local regions. In many ways, the perceived visionary leadership of the UDRHs, particularly with an emphasis on multidisciplinary, community-based team practice, has attracted those with similar views regarding the primacy of a multidisciplinary primary care approach to rural health services. This approach, grounded in a population health philosophy, has created the culture of networking and relationship-building which has characterised the work of the UDRHs.

‘‘The boss’ is the main reason I came [to the UDRH]. [the Head] is visionary, provides leadership, is supportive, has created a culture of teamwork rather than competition.’’
(UDRH staff member).
It was also noted that the character of the leadership influences the culture and focus of the organisation.

‘In other UDRHs people are not always given that respect and allowed to run with things; the environment at [this UDRH] is quite unique, different from other UDRHs; there’s a flatter structure, it’s much more team based; there’s a willingness to work together and support each other, lots of training on working together as a team, making sure we’re all linked in; the strength is the management style.’ (UDRH staff member)

The heads of each UDRH form the executive board of their peak body, ARHEN, and through this body the combined UDRHs have contributed to advocacy for rural health services at a national level.

A majority of staff who were consulted exhibited enthusiasm, passion and outstanding commitment to their own work and the work of the UDRH. Indeed, as one Department Head commented,

‘We tend to find the staff first, and then create a job description… It’s the quality of the staff that makes it work.’

Vision and strategic planning

The vision of transformation of the rural health workforce has been a sustaining driver for many working within the UDRHs. Small but real successes, such as the retention of a nurse or psychologist within the community, or the ability of a physiotherapist to undertake graduate studies while remaining in practice in the country, are celebrated as evidence of the UDRH contribution to the provision of rural health services and, by extension, to the quality of life for people living in rural communities.

UDRHs depend upon the development of community, regional and national relationships for their survival. Their limited core funding requires UDRHs to seek outside opportunities to achieve the objectives which have been set for the Program. These have taken the form of partnerships with local health services and other health service agencies, applications for grant funding from a range of funding bodies, links with community groups and health professionals, and contractual arrangements with State/Territory-funded health agencies. This has been named as some as the catalyst for innovation, and a contributing factor to improved population health services and research.

Supported information technology

The establishment of high-quality, cutting-edge videoconferencing technology in regional, rural and remote locations has been one of the greatest enablers, and also one of the most significant achievements, of the UDRH Program. Facilities which allow videoconferencing mean that distance learning opportunities can be provided to people hundreds of kilometres away from the lecture theatre, or that academic supervision can be given for individuals undertaking research projects in remote locations. Increasingly lectures are also available as podcasts so that students can access them at their leisure. Access to the internet and electronic access to university library resources have also facilitated health practitioners’ ability to undertake continuing studies or research while remaining in practice. These same facilities have also made the option of rural placements and training more attractive to students.

Crucial to the success of the IT in facilitating UDRH programs, however, is the support provided by dedicated, full time IT staff, the presence of whom minimises the frequency and impact of inevitably occurring difficulties (e.g. with video conferencing, and internet connections). The IT facilities are also costly to install and require ongoing investment and maintenance to ensure that the capacity of the system meets the requirements of providing distance learning and other communication opportunities to rural and remote Australia. The full potential of the IT resources has not yet been realised, with UDRH-university linkages only being as good as the current band width allows.
4.5.2 Limiting factors

Funding

A number of staff spoke of the UDRHs as ‘fragile’ due to the restricted funding of the UDRH Program, with one staff member indicating that a number of positions and program opportunities would be lost in the next year, because of the inability to stretch the current funding to cover the increasing costs of employing staff. Other UDRHs have acknowledged the difficulty and have increased their efforts to create partnerships and innovative projects which allow for sharing of resources with other agencies. All UDRHs, however, have indicated that the ability to continue to provide the range of projects and opportunities will be compromised in the future without a real increase in the funding for the Program.

There are two additional consequences of the limited funding which arise: the inability of the UDRHs to provide an adequate level of resourcing and support for the increasing number of students who undertake placements, and the potential for staff burnout in light of increasing demands on UDRHs without a corresponding ability to employ staff to meet those requirements.

A defining characteristic of UDRHs has been their innovation in approaching research, training and partnerships. One way of approaching the limitations of funding might be to develop a separate pool of innovation funding, which would allow those UDRHs who are seeking to grow and develop to apply for additional, competitive funding to support research and development in partnership with State- or Territory-funded and private health services, community organisations, and other agencies. Creating a separate pool of funding which could be accessed (by competitive application) to increase their revenue might relieve some of the pressure felt by some UDRHs who are eager to explore new models of service delivery and population health responses, but are constrained by the lack of resources to do so. It was noted by several informants that the time required simply to find and then apply for alternative sources of funding is costly, so the availability of a dedicated innovation pool might also ease the pressure of seeking other funding sources.

The need to provide financial support, accommodation and/or bursaries for students is an additional limiting factor which impacts on the operation of UDRHs. Students who travel from the city to the country for short-term placements often leave family and work commitments behind; in addition, due to the short-term nature of placements many students continue to pay rent or mortgage payments for their urban accommodation. Students sometimes face a significant cost in undertaking a rural placement. Most UDRHs have sought to provide some form of accommodation or at the least a bursary for students. In some areas, particularly those experiencing a mineral boom or population growth, accommodation is in short supply and prices have risen astronomically in recent years, as have associated costs of petrol and food. This provides a strain on both the UDRH and the individual students. Addressing the costs incurred by nursing and allied health students (which are not usually faced by medical students due to the greater level of resources available) might assist in ensuring that the placements are positive experiences which can influence later career decisions.

Disciplinary silos

There is an increasing understanding of the positive impact of multidisciplinary teamwork in health services, and of the benefits of interprofessional education. Breaking down disciplinary silos, that is, integrating training in various health disciplines has been identified by many informants as a benefit of the UDRHs. A strongly community-based, population health approach to rural health care services is evident within all UDRHs. The fact that UDRHs assist with placements and training for all health disciplines ensures that there is a range of perspectives, and cultures, regarding the provision of health services. Many participants stated that creating a strong, multidisciplinary workforce was an important goal for the future of rural health care. Others spoke of the opportunities which UDRHs provided for students from various disciplines to interact with and learn from each other, inculcating at an early stage the idea that health care provision could (and should) be multidisciplinary.
However, the size and scale of medical education (including the considerable material support available for medical students) ensures a continuing perception that medicine is the primary focus of health care services – to the detriment of nursing and allied health care disciplines. This is markedly more evident in UDRHs which are co-located with established RCSs. There are a number of reasons for this continuing perception:

- Although numerically the number of nursing and allied health students is greater than the number of medical students, medical students generally undertake longer term placements and are therefore more visible within the community;
- The funding of medical students is so disproportionate to the support available to nursing and allied health students as to perpetuate the perception that medicine is commensurately more important than any other discipline.
- The funding provided to UDRHs (which have a multidisciplinary mandate) is significantly less than the RCSs (which have a single disciplinary focus on medicine). Importantly, this extends to the ability to fund or otherwise support clinicians who have academic or supervisory roles.
- The fact that rural placements are mandated, and quotas issued, by medical programs, whereas they are not by other health disciplines, appears to impact on the importance placed on medical placements.

While recognising that the medical workforce is crucial, and that there are higher community expectations of the need for doctors in rural settings, it is also true that other disciplines are essential to a functioning health system. Addressing the balance at the student level in terms of support for students may assist in strengthening nursing and allied health recruitment and retention.

**Dependence on State/Territory health services**

With their multidisciplinary focus, the UDRHs relate closely to State- or Territory-funded health services, hospital-based services, and local private providers who may also work within the public health system. The ability of State or Territory health systems to provide placements for students, particularly nursing students, is critical in the aim of training students outside of the metropolitan teaching hospitals. One particular challenge is the widespread reliance on locum doctors or agency nurses, which does not provide the stability or continuity needed for teaching and supervision.

‘There’s an explosion of agency staff – it’s attractive for them and they earn a lot but there is resentment from staff nurses and less commitment from transient staff – it’s hard on the permanent staff.’ (UDRH nursing academic)

The recent Report on the audit of health workforce in rural and regional Australia (Department of Health and Ageing 2008b) found that on the whole nurses were evenly distributed across the nation, there were distribution variations in some rural and remote locations, and under-representation of some specialties, such as midwifery and mental health nursing. The audit also noted that there was a shortage of clinical educators available to teach and supervise within public hospitals.

The ability of the health system to accommodate increased numbers of students is a key factor in ensuring that the investment in the UDRH Program leads to a return through creating additional rural practitioners. However, as will be discussed in the next chapter, these workforce initiatives are interdependent upon the larger health system, with the UDRH needing to work with health services to provide training placements, and health services needing to gain rural-ready clinicians.

**Difficulty in recruiting**

UDRHs recognise that they themselves are contributing to the rural health workforce by recruiting and retaining health academics and clinicians. The presence of university infrastructure in rural settings has been noted by many as a positive influence on a local community, by encouraging students to see the possibility of a rural health career, by providing opportunities for local health professionals to continue their education, and by indicating a commitment on the part of the university and the government to the
viability of rural communities. However, the UDRHs face the same difficulties in recruiting and retaining staff as do the health systems they are seeking to support.

‘We are very ‘fragile’ in terms of staffing, but having staff here contributes to the local workforce, if we weren’t here, people with an interest in academia wouldn’t have stayed.’

(UDRH staff member)

4.6 Summary

The UDRH Program has been well established, ten years from its inception, and all eleven UDRHs are meeting the objectives of the Program. Nationally, the UDRHs have made significant contributions to rural clinical training, rural health service innovation and population health research, and increased rural community engagement with health promotion and population health awareness.

There is anecdotal evidence that rural student placements reinforce student intentions to practice rurally, and also evidence that some practitioners have been recruited to rural practice because of the presence of the UDRH. There is also evidence that the UDRHs have influenced rural and remote practitioners to remain in practice, through providing additional professional and personal networking and support, professional development opportunities, access to university resources, and incentives to undertake research.

Overall, UDRHs have demonstrated strategic leadership and vision in creating a rural university infrastructure which can influence the development and improvement of rural health services, and have increased communication and knowledge transfer through increased information technology. Challenges to the Program include funding constraints, disciplinary silos, and difficulties in recruiting staff and ensuring the capacity for clinical placements. However, each UDRH has sought to minimise these limitations and to maximise their capacity to strengthen the rural health workforce.